# Toh Sek Cheong v Great Eastern Life Assurance (M) Bhd

HIGH COURT (IPOH) — CIVIL SUIT NO 22NCVC-9–01 OF 2016
SM KOMATHY JC
14 DECEMBER 2016

*Insurance — Life insurance — Duty of disclosure — Plaintiff took insurance policy from defendant — Plaintiff claimed under policy after underwent heart surgery — Defendant refused plaintiff's claim — Legislation applicable to policy — Whether plaintiff disclosed facts required of him under s 150 of the Insurance Act 1996 — Whether plaintiff's spinal surgery and hypertension history material facts to underwriting of policy — Whether suppression of material facts fraudulent — Financial Services Act 2013 s 129 — Insurance Act 1996 s 150*

The plaintiff took out an insurance policy ('the policy') with the defendant on 17 November 2001 and had claimed under the said policy after he underwent a heart surgery in Singapore on 29 October 2014. Subsequently the defendant found that the plaintiff had failed to disclose in the proposal form that he had undergone a previous spinal surgery and/or that he was suffering from hypertension prior to the proposal of the policy. Consequently the defendant repudiated the plaintiff's claim and forwarded the policy to the defendant's customer service department for re-underwriting. The plaintiff then filed the present action against the defendant claiming for the sum due under the policy. The principal issue for determination was whether the plaintiff's failure to make disclosure of his spinal surgery and hypertension history were matters which entitled the defendant to withdraw their cover and repudiate the contract. In determination of the principal issue, there were sub-issues to be considered which were: (a) whether the plaintiff disclosed the facts required of him under s 150 of the Insurance Act 1996; (b) whether the plaintiff's spinal surgery and hypertension history were material facts to the underwriting of the policy; and (c) whether the suppression of material facts fraudulent. There was also disagreement between the parties as to the legislation applicable to the policy ie the Financial Services Act 2013 ('the FSA') or the Insurance Act 1996 ('the Act').

**Held,** dismissing the plaintiff's claim with costs of RM30,000:

(1) The policy was issued to the plaintiff on 17 November 2001, ie before the FSA came into force, thus, pursuant to s 129 and Schedule 9 of the FSA, the defendant was correct that the legislation applicable to the policy was the Insurance Act 1996 (see para 26).

(2) Based on the plaintiff's admissions in his testimony, it could not be gainsaid that the information declared by the plaintiff in the proposal

form, in the face of his statutory duty to disclose, was incorrect and untrue, and a breach of his statutory duty under s 150 of the Act. Even if the plaintiff's allegation that although he was prescribed with hypertension medication, he had not taken any medication for hypertension because he was able to manage his hypertension was true, that did not relieve the plaintiff of his duty to disclose the condition under the contract of insurance (see paras 34–35).

(3) All information sought in the proposal form was material. The proposal form sought information on whether the plaintiff had hypertension or had undergone surgery, making this information material facts to the underwriting of the policy (see para 44).

(4) The hypertension history and spinal surgery were material factors affecting the defendant's assessment of the risk at the time that it agreed to cover the plaintiff, that was a material fact which he had failed to disclose, thus, there was suppression of material facts (see para 46).

(5) In the plaintiff's answers to the proposal form, he had not only failed to disclose what was material for him to disclose but he had made false statement to the effect that he had not been treated for and never received any treatment for, inter alia, blood pressure, disorder and disease of bones, undergone any operation, or was previously hospitalised. On the facts, it was abundantly clear the plaintiff was guilty of fraudulent suppression of material facts. The defendant was thus entitled to avoid the policy on that ground (see paras 52–53).

**[Bahasa Malaysia summary**

Plaintif mengambil polisi insurans ('polisi') dengan defendan pada 17 November 2001 dan telah menuntut di bawah polisi tersebut selepas dia menjalani pembedahan jantung di Singapura pada 29 Oktober 2014. Seterusnya defendan mendapati bahawa plaintif gagal untuk mendedahkan dalam borang cadangan bahawa dia telah menjalani satu pembedahan tulang belakang sebelum ini dan/atau dia mengalami hipertensi sebelum cadangan polisi. Akibatnya defendan menolak tuntutan plaintif dan mengemukakan polisi itu kepada jabatan khidmat pelanggan defendan untuk pengunderaitan semula. Plaintif kemudian memfailkan tindakan ini terhadap defendan menuntut untuk jumlah tertunggak di bawah polisi. Isu utama untuk penentuan adalah sama ada kegagalan plaintif untuk membuat pendedahan pembedahan tulang belakangnya dan sejarah hipertensi adalah perkara yang mana memberi hak kepada defendan untuk menarik balik perlindungan dan menolak kontrak. Dalam penentuan isu utama, terdapat sub-isu yang perlu dipertimbangkan iaitu: (a) sama ada plaintif mendedahkan fakta yang dikehendaki ke atasnya di bawah s 150 Akta Insurans 1996; (b) sama ada pembedahan tulang belakang dan sejarah hipertensi plaintif adalah fakta material kepada pengunderaitan polisi; dan (c) sama ada penyekatan fakta

material berupa fraud. Terdapat juga perbezaan pendapat antara pihak terhadap undang-undang yang terpakai terhadap polisi iaitu Akta Perkhidmatan Kewangan 2013 ('APK') atau Akta Insurans 1996.

**Diputuskan,** menolak tuntutan plaintif dengan kos sebanyak RM30,000:

(1) Polisi dikeluarkan kepada plaintif pada 17 November 2001, iaitu sebelum APK berkuatkuasa, maka, menurut s 129 dan Jadual 9 APK, defendan adalah betul bahawa undang-undang terpakai kepada polisi adalah Akta Insurans 1996 (lihat perenggan 26).

(2) Berdasarkan pengakuan plaintif dalam testimoninya, ia tidak boleh dinafikan bahawa maklumat yang dideklarasi oleh plaintif dalam borang cadangan, dalam menghadapi tanggungjawab statutorinya untuk mendedahkan, adalah salah dan tidak benar, dan satu pelanggaran tanggungjawab statutorinya di bawah s 150 Akta. Jika pun dakwaan plaintif bahawa walaupun dia telah dipreskripsikan dengan ubat hipertensi, dia tidak mengambil apa-apa ubat untuk hipertensi kerana dia boleh mengawal hipertensinya adalah benar, ia tidak melepaskan plaintif daripada tanggungjawabnya untuk mendedahkan keadaan itu di bawah kontrak insurans (lihat perenggan 34–35).

(3) Semua maklumat diminta di dalam borang cadangan adalah material. Borang cadangan meminta maklumat sama ada plaintif mempunyai hipertensi atau telah menjalani pembedahan, menjadikan maklumat ini fakta material terhadap pengunderaitan polisi (lihat perenggan 44).

(4) Sejarah hipertensi dan pembedahan tulang belakang adalah faktor material yang menjejaskan penilaian risiko defendan sewaktu ia bersetuju untuk melindungi plaintif, itu adalah fakta material yang mana dia telah gagal untuk didedahkan, maka, terdapat penyekatan fakta material (lihat perenggan 46).

(5) Dalam jawapan plaintif terhadap borang cadangan, dia bukan hanya gagal untuk mendedahkan apa yang material untuk didedahkannya, tetapi dia telah membuat kenyataan palsu yang menyatakan bahawa dia tidak pernah dirawat untuk dan tidak pernah menerima apa-apa rawatan untuk, antara lain, tekanan darah, masalah dan penyakit tulang, menjalani apa-apa pembedahan, atau pernah dimasukkan ke hospital sebelum ini. Pada fakta, ia adalah amat jelas plaintif bersalah atas fraud penyekatan fakta material. Defendan oleh itu berhak untuk menafikan polisi atas alasan itu (lihat perenggan 52–53).]

**Notes**

For cases on duty of disclosure, see 8(1) *Mallal's Digest* (5th Ed, 2015) paras 245–250.

**Cases referred to**

*Leong Kum Whay v QBE Insurance (M) Sdn Bhd & Ors* [2006] 1 MLJ 710, CA (refd)
*Mithoolal v Life Insurance Corporation of India* [1962] AIR 814, SC (refd)
*Sinnaiyah & Sons Sdn Bhd v Damai Setia Sdn Bhd* [2015] 5 MLJ 1; [2015] 7 CLJ 584, FC (refd)
*Yew Wan Leong v Lai Kok Chye* [1990] 2 MLJ 152, SC (refd)

**Legislation referred to**

Contracts Act 1950 s 17
Financial Services Act 2013 s 129, Schedule 9
Insurance Act 1996 (repealed by Financial Services Act 2013) ss 147(4), (5), 150, 150(1)
Life Insurance Act 1938 [IND] s 45

*Augustine Anthony (Augustine Anthony) for the plaintiff.*
*Wong Hok Mun (Martin Cho Cheng Yu with him) (Azim, Tunku Farik & Wong) for the defendant.*

**SM Komathy JC:**

INTRODUCTION

**[1]** In this action, the plaintiff, Mr Toh Sek Cheong, a chartered accountant, is claiming the sum RM200,000 which, he says, is due under a policy of insurance dated 17 November 2001 ('the policy') he took out with the defendant, Great Eastern Life Assurance (M) Bhd. In addition to the sum payable under the policy, the plaintiff also claims damages of between RM3.67m to RM6.67m.

BACKGROUND FACTS

**[2]** There is no dispute on the background facts that led to this litigation. I adopt with gratitude the facts as outlined by counsel in their submissions.

**[3]** The policy, which is the subject matter of this action, is called 'Supreme Livin Care — Whole Life Living Assurance with Cash Bonus'. It is a life policy which provides coverage for death, total and permanent disability as well as a living assurance benefit.

**[4]** The plaintiff applied for the policy by a proposal form dated 6 November 2001 ('the proposal form') and the policy was issued to him on 17 November 2001. Based on the information provided in the proposal form, the defendant rated the plaintiff as 'standard rate', and required him to pay a

standard premium rate for the policy as the proposal form indicated that he posed a normal risk profile, without any existing or potential health complications. The plaintiff paid the premium.

**[5]** The plaintiff underwent heart surgery in Singapore on 29 October 2014 and made a claim under the policy. Heart surgery was one of the events stated in endorsement 51(LAP) of the policy which entitled the plaintiff to make a claim on the policy under the living assurance coverage. On 23 December 2014, the defendant received from the plaintiff a copy of a living assurance claim form dated 22 December 2014, confidential medical certificate dated 6 December 2014, medical report issued by the National Heart Centre Singapore and inpatient discharge summary issued by the National Heart Centre Singapore.

**[6]** In the process of assessing the plaintiff's claim, the defendant noted:

(a) at section 1 question 2 of the plaintiff's medical certificate, the plaintiff's attending doctor answered in the 'positive' to the question whether the plaintiff had previously suffered from or had been detected to have, inter alia, hypertension;

(b) in the plaintiff's medical report, the plaintiff's attending doctor stated that the plaintiff had a medical history of hypertension and had also undergone surgery for L4, L5 fusion 20 years ago;

(c) at the plaintiff's inpatient discharge summary, the plaintiff's attending doctor stated that the plaintiff had a medical history of hypertension and also had undergone surgery for L4, L5 fusion 20 years ago; and

(d) that in the proposal form the plaintiff had declared that he had never suffered and never received any treatment for, inter alia, blood pressure, disorder and disease of bones, undergone any operation, or was previously hospitalised.

**[7]** By reason of the foregoing, the defendant by letter dated 30 December 2014 requested from the plaintiff the following documents/information:

(a) name, contact number and address of all the doctors whom the plaintiff had consulted in the past three years;

(b) hypertension questionnaire to be completed by the plaintiff's treating doctor;

(c) hypertension questionnaire to be completed by the plaintiff honestly; and

(d) information relating to the plaintiff's surgery for L4, L5 fusion.

**[8]** The plaintiff responded within 22 days by his letter dated 20 January 2015 and enclosed, inter alia, the following documents: A

(a) a copy of the hypertension questionnaire form dated 20 January 2015 duly completed and signed by the plaintiff himself; and

(b) a copy of the hypertension questionnaire form dated 15 January 2015 duly completed and signed by the plaintiff's treating doctor, Dr LS Ludher. B

**[9]** The defendant perused these documents and noted the following matters: C

(a) the plaintiff admitted that he had undergone spinal surgery some 23 years ago (before the proposal form) and requested for a waiver in furnishing the documents pertaining to his spinal surgery because he was unable to secure the same from the then treating hospital, Mount Elizabeth Hospital; D

(b) in question 1 of the plaintiff's hypertension questionnaire form, the plaintiff answered that he was first diagnosed with hypertension in year 1992 (nine years before the proposal form); E

(c) in question 2 of the plaintiff's hypertension questionnaire form, the plaintiff answered that he was on continued medication ie plendil 5mg–10mg, exforge 5/85 mg, and cozaar 5/100;

(d) in question 3 of the plaintiff's hypertension questionnaire form, the plaintiff answered that he visits his attending physician about once in every two months; F

(e) in question 1 of the plaintiff's doctor's hypertension questionnaire form, the plaintiff's doctor answered that the plaintiff was first diagnosed with hypertension in year 1992 (nine years before the proposal form) and has since been taking plendil daily as medication; and G

(f) in question 4 of the plaintiff's doctor's hypertension questionnaire form, the plaintiff's doctor answered that the plaintiff's heart has suffered damages as a result of his hypertensive condition. The plaintiff's doctor has also stated that the damage to the heart due to the elevated blood pressure was the mitral valve prolapse with left ventricular enlargement. H

**[10]** In light of the above, the defendant took the view that the proposal form contained untrue statements as the plaintiff knew and was fully aware of his spinal surgery and his hypertension history but had declared otherwise in the proposal. I

**[11]** The defendant by letter dated 23 April 2015 repudiated the plaintiff's claim on the grounds of fraudulent non-disclosure of his hypertensive condition in the proposal form and the policy was subsequently forwarded to the defendant's customer service department for re-underwriting. In the same letter the defendant also informed the plaintiff, as required by Bank Negara Malaysia ('BNM'), that he may refer his claim to BNM if he was unsatisfied with the defendant's decision to repudiate his policy.

**[12]** The defendant decided to avoid the policy from inception upon re-underwriting, and by letter dated 15 May 2015 informed the plaintiff of its decision. The defendant had also informed the plaintiff that all the premium paid under the policy will be refunded to him in due course as the policy was deemed null and void.

**[13]** The plaintiff issued a without prejudice letter dated 20 May 2015 to the defendant, reserving his right to pursue his claim as he deemed fit. The defendant reverted to the plaintiff by its letter dated 25 June 2015, and maintained that the policy was rightly avoided due to the plaintiff's fraudulent non-disclosure of his hypertensive condition in the proposal form.

**[14]** A month later, the plaintiff instructed his solicitors Messrs Augustine Anthony to issue a letter of demand dated 28 July 2015 to the defendant demanding the defendant to pay on the policy. In response, the defendant vide Messrs Azim, Tunku Farik & Wong's letters dated 10 August 2015 and 24 August 2015, reverted stating that the defendant maintained its position that the policy ought to be avoided from inception on account of the plaintiff's fraudulent non-disclosure in the proposal form.

**[15]** The plaintiff then lodged a complaint to BNM dated 7 September 2015. BNM by a letter to the defendant dated 9 September 2015, requested the defendant to provide the plaintiff with an explanation within two weeks from 9 September 2015.

**[16]** In response, the defendant by letter to the plaintiff dated 10 September 2015 acknowledged receipt of the plaintiff's complaint form and BNM's letter dated 9 September 2015:

(a) vide a letter dated 15 September 2015 together with a cheque dated 11 September 2015, refunded the sum of RM122,037.30 to the plaintiff, being all the premium paid under the policy; and

(b) vide a letter dated 21 September 2015 replied and explained to the plaintiff GELM's grounds of repudiation in detail.

**[17]** BNM after reviewing the plaintiff's complaint, concluded and concurred that the defendant had acted in accordance to the terms and conditions of the policy and that the defendant's decision to repudiate the plaintiff's claim and avoid the policy were correct and in order.

**[18]** The plaintiff banked in the cheque into his account.

**[19]** On 12 January 2016, the plaintiff instituted the present suit against the defendant.

THE PLAINTIFF'S CASE

**[20]** The plaintiff's case can be outlined briefly as follows:

(a) the defendant maliciously and/or dishonestly and/or fraudulently and/or negligently repudiated his claim and avoided the policy;

(b) the defendant intentionally delayed in the assessing and processing of his claim and maliciously and/or deliberately and/or oppressively requested for irrelevant information and/or documents from the plaintiff; and

(c) the defendant deliberately and illegally collected premium and asked for further documents from his attending doctor after the defendant avoided the policy.

**[21]** In consequence thereof, the plaintiff has suffered damages, pain and suffering, distress, loss of dignity and confidence, emotional and mental injury and sought, inter alia, the following reliefs:

(a) a declaration that the actions and conduct of the defendant in repudiating the policy were unlawful and void;

(b) a declaration that the policy was valid/legal and enforceable;

(c) all the benefits under the policy amounting to RM200,000 with cash bonus and an additional sum of RM80,000 for the 'deferred term assurance and/or differed whole life';

(d) general damages in the sum of RM500,000;

(e) exemplary damages in the sum of RM2m–RM5m; and

(f) aggravated damages in the sum of RM1m.

THE DEFENDANT'S CASE

**[22]** The defendant in its defence denied the plaintiff's allegations and maintained that its repudiation of the policy was lawful as there were intentional material non-disclosures on the part of the plaintiff pertaining to

his medical history, particularly when the plaintiff failed to disclose in the proposal form that he had undergone a previous spinal surgery and/or that he was suffering from hypertension prior to the proposal for the policy. It was said that its liability was conditional upon the facts in the proposal form being true.

ISSUES

**[23]** The principal issues here are whether the plaintiff's failure to make disclosure of his spinal surgery and hypertension history were matters which entitled the defendant to withdraw their cover and repudiate the contract; and the damages payable, if any.

THE TRIAL

**[24]** The hearing of the trial took place on 14 and 15 August 2016. The plaintiff gave evidence and called his wife ('SP2') and sister ('SP3') as his witnesses. The defendant called three witnesses. They were Miss Chin Jia Gi ('SD1'), a manager in the claims department, Miss Teh Lay Hwa ('SD2'), a senior manager in the new business department, and Miss Lim Pei Chin ('SD3'), the assistant vice president and head of product pricing.

**[25]** I will refer to their evidence as and when it is relevant.

THE APPLICABLE LEGISLATION

**[26]** The parties were in disagreement as to the legislation applicable to the policy. The plaintiff's counsel contended it was the Financial Services Act 2013 ('the Financial Services Act') whilst, the defendant's counsel maintained it was the Insurance Act 1996 ('the Insurance Act'). The policy here was issued to the plaintiff on 17 November 2001, ie before the Financial Services Act came into force. In my view, s 129 and Schedule 9 of the Financial Services Act indicate that counsel for the defendant is correct in the position he takes.

**[27]** For ease of reference, I set out s 129 of the Financial Services Act and Schedule 9 of the Financial Services Act:

> 129 Pre-contractual disclosure and representations, and remedies for misrepresentations:
>
> (1) Schedule 9 sets out the pre-contractual duty of disclosure and representations for contracts of insurance in Part 2, and the remedies for misrepresentations relating to contracts of insurance in Part 3.
>
> Schedule 9 Part 1
>
> 1 Application of Schedule and other laws:

*(1) This Schedule shall not affect a contract of insurance entered into, varied or renewed before the date on which section 129 and this Schedule come into operation.*

(Emphasis added.)

## DUTY TO DISCLOSE UNDER THE INSURANCE ACT

**[28]** I will deal briefly with the insured's duty to disclose information under common law before I examine what is the duty under the Insurance Act. An insurance contract is an *uberrimae fidei* contract in that it imposes a duty on the policy owner to exercise the utmost good faith and to make a full disclosure of all facts material to the insurer and should the policy owner fails to do so, his/her policy of assurance may be rendered null and void from inception.

**[29]** It is instructive in this connection to refer to the oft quoted case of *Leong Kum Whay v QBE Insurance (M) Sdn Bhd & Ors* [2006] 1 MLJ 710 where the Court of Appeal observed at pp 719–720:

> It is settled beyond dispute that a contract of insurance is one that imposes mutual duty on the parties to it to act uberrimae fides towards each other. On the part of the insured, he or she must make full and frank disclosure of all material facts. It is not for him or her to decide in his or her own mind what is material ... The duty is on the insured to make full disclosure of material facts within his knowledge.

**[30]** The law governing the duty of an insured to disclose information is embodied in s 150 of the Insurance Act. Section 150(1) modified the position in common law by providing:

> (1) Before a contract of insurance is entered into, a proposer shall disclose to the licensed insurer a matter that —
>
> (a) he knows to be relevant to the decision of the licensed insurer on whether to accept the risk or not and the rates and terms to be applied; or
>
> (b) a reasonable person in the circumstances could be expected to know to be relevant.

**[31]** It is clear from the foregoing that there was a statutory duty on the plaintiff to exercise utmost good faith and to make a full and frank disclosure of his medical history to the defendant. The rationale for this requirement is easy to discern. The taking on of an insurance risk would become onerous if the insurer cannot rely on the full and fair disclosure of the insured regarding facts material to the risk which are within the knowledge of the party seeking insurance cover. Without such information, the insurer will be unable to properly assess the risk it is undertaking and whether to accept the risk and, if so, at what rate to set the premium. It would be unfair to require the insurer to

take on the risk without all the relevant facts.

WHETHER THE PLAINTIFF COMPLIED WITH HIS STATUTORY DUTY

**[32]** The next question is whether the plaintiff disclosed the facts required of him under s 150. It is critical to note that the plaintiff in his testimony acknowledged two pertinent facts:

(a) that he had undergone spinal surgery and received treatment from Doctor Chan Heng Thye at Mount Elizabeth Hospital Singapore around 1992, which is prior to his application and/or proposal for the policy;

(b) that he was first diagnosed with high blood pressure 'hypertension' in year 1992, which is also prior to his application and/or proposal for the policy.

**[33]** This flies in the face of the information he had provided in the proposal form where he had expressly declared that he has never suffered and never received any treatment for, inter alia, blood pressure, disorder and disease of bones, undergone any operation, nor previously hospitalised. It is apposite to mention here that there was an express condition in the proposal form signed by the plaintiff that was in these terms:

> Important Notice: You are to disclose in this proposal from and any other questionnaire(s) and or personal statement(s), if any, fully and faithfully all facts which you know or ought to know otherwise the policy if issued may be invalidated. If you are in doubt about whether certain facts are material. These facts should be disclosed.

**[34]** Based on the plaintiff's admissions as aforesaid, it cannot be gainsaid that the information declared by the plaintiff in the proposal form, in the face of his statutory duty to disclose, was incorrect and untrue, and a breach of his statutory duty under s 150.

**[35]** In passing I should mention that even if the plaintiff's allegation that although he was prescribed with hypertension medication in 1992, he had not taken any medication for hypertension because he was able to manage his hypertension through diet, exercise and lifestyle without relying on any further hypertension medication is true, that does not relieve the plaintiff of his duty to disclose this condition under the contract of insurance.

**[36]** The plaintiff's failure to make full and candid disclosure about his medical history does not conclude this case in the defendant's favour. There is one remaining issue.

WHETHER S 147(4) OF THE INSURANCE ACT

**[37]** The remaining issue has to do with the requirements of s 147(4) of the Insurance Act which are in these terms:

> Mis-statement of age and non-avoidance of policy
>
> (4) A licensed life insurer shall not dispute the validity of a life policy after the expiry of two years from the date on which it was effected on the ground that a statement made or omitted to be made in the proposal for insurance or in a report of a doctor, referee, or any other person, or in a document leading to the issue of the life policy, was inaccurate or false or misleading *unless the licensed life insurer shows that the statement was on a material matter or suppressed a material fact and that it was fraudulently made or omitted to be made by the policy owner.* (Emphasis added.)

**[38]** The second part of s 147(4) provides that a policy that has been effective for more than two years prior to repudiation can only be avoided if the insurer can show that the answers provided by the insured in the proposal form amounted to fraudulent suppression of the material facts.

**[39]** The Indian Supreme Court in *Mithoolal v Life Insurance Corporation of India* [1962] AIR 814 dealt with the pre-conditions that must be fulfilled before an insurer can resort to avoid a policy under s 45 of the Indian Life Insurance Act 1938 (which is in pari materia to s 147(4) of the Insurance Act). The Indian Supreme Court held that:

> The three conditions for the application of the second part of s 45 are:
>
> (a) the statement must be on a material matter or must suppress facts which it was material to disclose;
>
> (b) the suppression must be fraudulently made by the policy-holder; and
>
> (c) the policy-holder must have known at the time of making the statement that it was false or that it suppressed facts which it was material to disclose.

**[40]** This means the defendant would only be entitled to repudiate or avoid the policy in the present instance if it can show that the plaintiff's failure to disclose his spinal surgery and hypertension history amounted to fraudulent suppression of the material facts by the plaintiff. In other words that he knew that the information he gave in the proposal form were false.

WHETHER THE PLAINTIFF'S SPINAL SURGERY AND HYPERTENSION HISTORY WERE MATERIAL FACTS

**[41]** I turn now to consider whether the plaintiff's spinal surgery and hypertension history were material facts to the underwriting of the policy. Section 147(5) of the Insurance Act defines 'material facts' as follows:

A For the purpose of subsection (4), 'material matter' or 'material fact' means a matter or fact which, if known by the licensed life insurer, would have led to its refusal to issue a life policy to the policy owner or would have led it to impose terms less favourable to the policy owner than those imposed in the life policy.

B **[42]** The author S Santhana Dass in *Law of Life Insurance in Malaysia* at p 95 expressed the view that:

All information sought by way of the question in the proposal form are deemed material ... May J in *March Cabaret Club & Casino Ltd v Thompson and Byran Ltd* [1975] 1 Lloyd's Rep 169, when he said:

C there is a presumption that matters dealt with in the proposal form are material ...

**[43]** I concur with the aforesaid view that all information sought in the D proposal form are material. The proposal form in the instant case sought specific information about the plaintiff's medical history. The questions at section VI are clear and unambiguous:

VI. HEALTH/MEDICAL INFORMATION

E ...

4. Have you ever suffered from *or* received any treatment for:

(f) Blood pressure, raised cholesterol, disease of the blood vessels or circulatory disorder?

(g) Disorder and disease of muscles, glands, bones, joints or limbs?

F (k) Other illness, disorder, operation, disability, accident or been hospitalised?

**[44]** The proposal form sought information on whether the plaintiff had hypertension or had undergone surgery, making this information material facts G to the underwriting of the policy. In this connection, I refer to Miss Teh Lay Hwa's explanation in her witness statement on why it was vital for the insurer to know if the insured had been diagnosed with hypertension:

From a medical stand point, hypertension, also known as high blood pressure, is a long term medical condition which will effectively put extra strain on a person's H heart and blood vessel and this additional pressure would increase the risk of getting heart attack, stroke, kidney disease, etc. From my experience, stroke and heart attack are the two most common claims we received for Critical Illness.

Insofar as the underwriting of a life related insurance product is concerned, since other medical issues can arise because of the insured's hypertension condition, there I is potentially an increase of risk of claims being made upon the policy. As such, the medical history of an insured is particularly important to the underwriters because the underwriters are required to evaluate the potential risk and to reflect the risk

factor, the underwriter may also increase the standard premium by adding what is referred to as a medical loading ...

Had the plaintiff's hypertension history been made known to GELM, and in considering the plaintiff's age when the proposal was made, the plaintiff's proposal may be rejected, or at the very least, *the terms and conditions, the premium sum and the benefit of the policy would be very much less favourable to the plaintiff than* those which have been provided in this current policy.

**[45]** In any event, the plaintiff acknowledged that his hypertension was one of the causative factors which led to his heart surgery in 2014.

**[46]** In answering the question whether there was non disclosure of material facts or suppression of material facts at the time of the submission of proposal, I am moved to accept that there was. It is plainly something which had to be exclusively within the knowledge of the plaintiff himself. The hypertension history and spinal surgery were material factors affecting the defendant's assessment of the risk at the time that it agreed to cover him, that is a material fact which he has failed to disclose, and on that score I find for the defendant and accept its submission that there was suppression of material facts.

WHETHER SUPPRESSION OF MATERIAL FACTS FRAUDULENT

**[47]** I propose to deal now with the second and third conditions on whether the suppression of the material facts was done fraudulently. The two issues are tied up together.

**[48]** The standard of proof for fraud in all civil cases was recently declared by the Federal Court in *Sinnaiyah & Sons Sdn Bhd v Damai Setia Sdn Bhd* [2015] 5 MLJ 1; [2015] 7 CLJ 584 to be the civil standard of balance of probabilities. In this regard, the court explained:

The correct principle to apply is as explained in *In Re B (Children)* where it was stipulated that at law, there are only two standard of proof, namely beyond reasonable doubt for criminal cases and on the balance of probabilities for civil cases. As such, even if fraud is the subject in a civil claim, the standard of proof is on the balance of probabilities. There is no third standard. Therefore, it is up to the presiding judge, after hearing and considering the evidence adduced as being done in any other civil claim, to find whether the standard of proof has been attained. The criminal aspect of the allegation of fraud and the standard of proof required is irrelevant in the deliberation.

**[49]** According to s 17 of the Contracts Act 1950, fraud is defined as:

'Fraud' includes any of the following acts committed by a party to a contract, or with his connivance or by his agent, with intent to deceive another party thereto or

his agent, or to induce him to enter into the contract:

(a) the suggestion, as to a fact, of that which is not true by one who does not believe it to be true;

(b) the active concealment of a fact by one having knowledge of belief of the fact;

(c) ...

(d) ...

(e) ...

**[50]** The plaintiff denied any fraudulent suppression of material facts. He alleged that he had forgotten about his spinal surgery and hypertension history at the time he signed the proposal form and was innocent of any deliberate non-disclosure. I do not believe him. His conduct subsequent to the signing of the proposal form demonstrates that this was not so. First, when the defendant by letter dated 30 December 2014, requested the plaintiff to furnish documents/information pertaining to his spinal surgery and hypertension diagnosis in 1992, he did so within 22 days in 1992. Secondly, he had remembered to disclose his spinal surgery and hypertension history to his heart surgeon in year 2014, and the details of his hypertension to his attending doctor, Dr LS Ludher in early 2015.

**[51]** Next, and crucially the plaintiff's response to questions put to him in cross-examination as to why he had forgotten to disclose his spinal surgery and hypertension history supports the defendant's position that it was done deliberately:

| | |
|---|---|
| Wong: | how many operation you have in your life Mr Toh? |
| Toh: | I guess if you say then this is. |
| Wong: | how many? |
| Toh: | do you consider extracting a teeth as an operation? |
| Wong: | no |
| Toh: | then I will say only two (2) |
| Wong: | so you only had two (2) operation, how lightly (sic) you forget that? |
| Toh: | how lightly? |
| Wong: | yes, how lightly is for you to forget only two (2) operation which you have had in your life? |
| Toh: | how lightly? |
| Wong: | yes |

Toh: *well I can choose not to remember things*

(Emphasis added.)

**[52]** In the light of these facts, I agree with counsel for the defendant that it is absolutely illogical for the plaintiff to maintain that he could not remember his medical history during the execution of the proposal form in year 2001, but could recollect the details of his medical history in 2014 and 2015. I do not think the plaintiff was likely to forget about his spinal surgery and hypertension history. In his answers to the proposal form he had not only failed to disclose what was material for him to disclose but he had made a false statement to the effect that he had not been treated for and never received any treatment for, inter alia, blood pressure, disorder and disease of bones, undergone any operation, or was previously hospitalised.

**[53]** It is abundantly clear the plaintiff is guilty of fraudulent suppression of material facts when he declared in the proposal form on 6 November 2011 to the effect that he had not been treated for and never received any treatment for, inter alia, blood pressure, disorder and disease of bones, undergone any operation, or was previously hospitalised. He knew these statements were false concealment of his spinal surgery and hypertension history from the defendant. In other words he had fraudulently suppressed these facts. The defendant was thus entitled to avoid the policy on that ground.

## THE OTHER ALLEGATIONS MADE BY THE PLAINTIFF AGAINST THE DEFENDANT

**[54]** I will also briefly address the remaining two allegations made by the plaintiff as outlined in para 20(b) of this judgment. There is no evidence to substantiate the allegation that the defendant intentionally delayed processing the plaintiff's claim and had maliciously and/or deliberately and/or oppressively requested for irrelevant information and/or documents from the plaintiff.

**[55]** On the contrary, the evidence indicates that the defendant had acted with reasonable speed in completing the whole process within five months. The plaintiff's allegation that the defendant had maliciously and/or deliberately and/or oppressively requested for irrelevant information and/or documents from him is also clearly bereft of merit. The defendant had a right to make enquiries and investigate the plaintiff's claim.

**[56]** As regards the complaint outlined in para 20(b) of this judgment, I also find no merit in it. The plaintiff alleged that the defendant has deliberately and illegally collected premium and asking for further documents from the plaintiff's attending doctor after the defendant avoided the policy. In this

connection it is relevant to refer to the evidence of Miss Chin Jia Gi ('SD1'):

> Q2: The plaintiff alleged that GELM has maliciously misrepresented to the plaintiff's bank on the basis that GELM has deducted the quarterly premium after having declared the policy null and void vide letter dated 15.5.2015. What do you have to say?
>
> A2: I disagree with the plaintiff's allegation. It is noteworthy that GELM is a big corporation which has multiple departments. Insofar as the premium collection is concerned, pursuant to GELM's record, GELM has in fact issued a premium notice dated 17.04.2015 at page 109 of the Common Bundle of Documents, which is prior to the date of repudiation.
>
> GELM came to the conclusion to void the Policy on 15.05.2015.
>
> Nonetheless, due to the payment mode of the Policy being vide credit card, the deduction instruction was already forwarded to the Bank by the auto debit feature of the credit card and the deduction was subsequently made on 16.05.2015, which is just one day after the Policy was declared void.
>
> In any event it must be noted that all premiums paid under the Policy ie the sum of *RM 122,037.30* had been fully refunded to the Plaintiff vide cheque dated 11.09.2015. As such I disagree that there is any malicious misrepresentation on the part of GELM whatsoever.
>
> Q3: The plaintiff alleged that GELM has vide the Letter dated 05.08.2015 to Klinik Regen at page 104 to 106 of the Common Bundle of Documents, purportedly solicited information about his medical history from Dr Ludher and has made false and malicious statement in the said letter by saying that GELM requires further details to accurately and fairly assess his claim when in fact GELM has already declared the policy null and void on 15.05.2015. What do you have to say?
>
> A3: I disagree with the plaintiff's allegation. At all material times, the letter dated 05.08.2015 is a standard template of the letter for assessment of claim. This letter was issued to Dr Ludher after GELM received the Letter of Demand from the plaintiff's solicitor, for the purpose of re-assessing the plaintiff's claim. It must be noted that Dr Ludher has answered in the plaintiff's doctor's Hypertension Questionnaire Form that the plaintiff was first diagnosed with hypertension in year 1992 (before the proposal form) and has been taking plendil daily as medication.

**[57]** I therefore find the allegations made by the plaintiff against the defendant are baseless and unfounded.

**[58]** The issue of damages does not arise.

OTHER MATTERS

**[59]** Before concluding, there are two other matters to which I wish to refer. First, counsel for the plaintiff in his written submissions presented extensive arguments on definitions and provisions set out in The European Parliament And The Council Of The European Union's, Unfair Commercial Practice

Code 2005 and the Financial Services Act to show that the conduct of the defendant in repudiating the policy was unlawful. Reliance on these definitions and provisions, in my judgment, is misconceived. The validity of the defendant's repudiation of the policy is governed by the provisions in the Insurance Act.

**[60]** Secondly, counsel for the plaintiff in his written submission contended that the facts showed the defendant had committed the tort of harassment, unfair and prohibited business conduct and had unjustly enriched itself. It seems to me that the plaintiff was trying to introduce an unpleaded case and I have no hesitation in concluding that that would not be appropriate.

**[61]** It is elementary that a party is bound by his pleading and this is illustrated by the decision of the Supreme Court in *Yew Wan Leong v Lai Kok Chye* [1990] 2 MLJ 152 where it was held that:

> ... reference was made to *Janagi v Ong Boon Kiat* [1971] 2 MLJ 196 in which Sharma J (as he then was) had made observations on the function of pleadings and the duty of courts to follow rules of procedure and practice. We agreed with the following passage in the judgment of the learned judge in that case in which His Lordship states:
>
> > The court is not entitled to decide a suit on a matter on which no issue has been raised by the parties. It is not the duty of the court to make out a case for one of the parties when the party concerned does not raise or wish to raise the point. In disposing of a suit or matter involving a disputed question of fact, it is not proper for the court to displace the case made by a party in its pleadings and give effect to an entirely new case which the party had not made out in its own pleadings. The trial of a suit should be confined to the pleas on which the parties are at variance.

**[62]** In any event, I find no evidence to substantiate these allegations. I must further point out that for these torts no damages was sought for these torts in the prayer for relief. I agree with counsel for the plaintiff that a claims of these nature must be expressly pleaded and the factual basis of it set out with clarity, and supported by witness statements.

CONCLUSION

**[63]** For the reasons stated, I dismiss the plaintiff's claim with costs of RM30,000.

*Plaintiff's claim dismissed with costs of RM30,000.*

Reported by Dzulqarnain Ab Fatar